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ABSTRACT

Case management as implemented in programs for the elderly, has focused on interactions between the client and case manager in the areas of assessment, care planning, service plan implementation, and follow-up. Variation in these case management tasks suggests that no single model can be implemented in all local delivery systems. This emphasis on client/case manager interaction has obscured the fact that care planning, a core case management task, is a crucial resource allocation activity and has important consequences for the distribution of resources within a local delivery system. A resource dependence view of interorganizational relationships is useful for analyzing the capacity of case managers to change market conditions by altering service providers' behavior. The extent of discretion over resource allocation and centralization of resource control are key case management design issues. Case management is a middle ground long-term care policy reform option. Its implementation does not require fundamental changes in funding patterns or interorganizational relationships. The middle ground in which case management can be developed as a reform option is wider than present operational experience suggests. Models that expand case management to include authority for resource allocation and implementation of financial incentives to influence market conditions deserve greater attention. (Author/NRB)

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CASE MANAGEMENT: LET US COUNT THE WAYS

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CASE MANAGEMENT: LET US COUNT THE WAYS

By this time the role of case management in programs for the aging is a familiar one. It has become an expected element in the design and delivery of services from multiple providers to an individual client. Based in the recognition that a client facing a complex and bewildering delivery system may need assistance with obtaining the services he/she desires, the case management role is a response to the fragmentation that pervades service delivery. The case manager coordinates and packages a set of appropriate services for the client. The importance of this integrating role is widely recognized and accepted. It is consistent with professional ideologies that call for treating the "whole" person and protecting the client from being fragmented by a fragmented delivery system.

Case management has been conceptually analyzed and operationally tested. Conceptually it encompasses a wide range of roles and functions including activities aimed at altering the local delivery system, as well as responsibilities for delivering services to individual clients. Operationally, actual experience indicates that case management has been performed based on a more restricted notion of the role, most often focused primarily on packaging services for clients. A review of the Services Integration Targets of Opportunity (SITO) experience under the Allied Services Act, an analysis of the extensive case management research undertaken at the Andrus Center at the University of Southern California, and a comprehensive review of nine home care demonstration projects support this view.

Operationally case managment is a coordinative mechanism that should be location contingent, that is, it is designed to fit within an ongoing service delivery network. It is a middle ground reform in the long term care delivery system, an option that does not require major restructuring of organizational relationships and funding patterns. By itself, however, case management will achieve only limited reform goals. In the absence of improved coordination and integration of funding and services,

case level coordination will not accomplish significant service delivery reform. The argument developed in this paper is that case management roles can be designed to incorporate elements which will enhance its potential to shape the behavior of providers, to contribute to cost containment efforts and to aide in capacity building endeavors at the local level. A resource dependence view of interorganizational behavior suggests criteria for assessing the potency of differing models of case management. This view suggests that the middle ground of reform in long term care has a wider range of options than operational testing to date has demonstrated. Characteristics of a potent model of case management will be presented and discussed.

Services Integration

The emergence of case management as an important mechanism for coordinated service delivery can be traced to the Allied Services Act. The Allied Services Act was proposed by then DHEW Secretary Elliot Richardson in 1971, in recognition of the need to improve coordination among HEW's own programs at both state and local levels. To this end HEW initiated a series of demonstration projects, the Services Integration Targets for Opportunity (SITO) grants, designed to test a variety of services integration mechanisms, primarily at the level of local service delivery[1]. Services integration techniques included newly developed information and referral systems, client tracking systems, comprehensive service centers and case management procedures. In 1974 HEW initiated the Partnership Grants program which represented an expansion of the SITO concept to include capacity building for services integration at state and local levels for the comprehensive planning and management capability components seen as necessary to support improvements in coordination of services at the delivery level. Forty-one sites were involved in the Partnership Grants program by June, 1975.

This federal initiative was an ambitious effort on two fronts, administrative reform at the state level (including the development of Comprehensive Human Resource Agencies (CHRA's)) and services integration (focusing attention on the client, the individual or family that frequently requested assistance from more than one categorical

program). Results of services integration efforts were to be seen at the level of service delivery. The intent of these efforts was to break down barriers between providers and to create a delivery system that was more responsive to clients' total needs.

The most common element in the SITO projects was the case manager. A search of Project Share in 1979 using the descriptor case management identified a large number of citations from the SITO projects. Eighteen of the citations were plans for services integration projects including case management as a component, eighty-seven were descriptions of case managment as implemented in the projects and fourteen identified evaluations of SITO projects with recommendations for improvements in case management efforts. Case managers in the SITO experience acted to assist clients in effective and efficient negotiation of the delivery system and served as the single point of accountability for client outcomes. Case managers were human service generalists, responsible for organizing resources for clients and for reliable transit of clients through the client pathway. Variation in case management in the SITO demonstrations was found with respect to function, status, responsibility for clients, role in the client pathway and source of accountability.[2]

The SITO experience produced several significant lessons. Projects implemented several integrative features including case management, client pathway, data units and service provider contracts. The SITO projects highlighted the complex relationships that exist between state and local administrative structures and the capacity to provide coordinated services to clients, that is the relationship between service delivery to clients and system structure. One of the major features shaping the delivery system affecting administrative arrangements and delivery of services to clients, was the structure of funding. Only one of the SITO projects attempted to change the flow of funding significantly.[3] A primary cause of fragmented services is fragmented funding. SITO projects' experience suggests that without modifications of the structure of funding, the progress toward evolution of integrated delivery systems would be thwarted.

Case Coordination Research at the Andrus Gerontology Center

A team of researchers at the Andrus Gerontology Center of the University of Southern California has been involved in an extensive examination of operational case coordination experience in programs for the vulnerable elderly across the nation. This investigation has produced an extensive bibliography,[4] a census of case coordination programs generated by a national survey,[5] a comprehensive list and analysis of practice guidelines drawn from the operational experience of case coordinators[6] and an assessment of the ways in which case coordination efforts have been evaluated.[7]

This research has highlighted the complexity of the case coordination function and the case management role. In a report of the proceedings from a Symposium attended by Front-Line Practitioners in Case Coordination (January 1979) a wide range of topics were identified and discussed including: the roles of the coordinator, the agency setting, the practice process, the importance of being able to differentiate among clients th varying levels of need, necessary background and training of coordinators and values held by individuals performing the case coordination function.[8] This ambitious effort has analyzed the case manager as coordinator, advocate and counselor,[9] examined the relationship between client pathway, assessment and case management,[10] and has investigated the impact of case coordination on Senior Centers[11] and an Area Agency on Aging.[12]

The proceedings of the Symposium of Front Line Practitioners report a description of the case management role at the task level as identified by Symposium participants. Symposium participants represented twelve case coordination agencies,[13] whose programs had been operational a minimum of two years and whose target population was the elderly. Each participant had a minimum of two years job experience and was currently employed as a direct service coordinator. The task level description was reported as frequencies, that is, how frequently did symposium participants indicate they performed each task. (Performed by all participants, frequently reported (most reported), reported by some participants (less than half).) This analysis has been extended (see Table 1)

TABLE 1

CASE MANAGEMENT TASKS[14]

	All Participants Reported	Frequently Reported (Most)	Some (Less Than Half) Reported
Individual Client Related Tasks	- referral - assessment - service plan development --arranging for services --coordination of service providers --resource development for individual clients - follow-up and reassessment - service plan alteration - advocacy - support and encouragement re: service utilization	- written service plan - maintain ongoing contact with clients - monitoring client medication - case consultation to other agencies - monitoring service provision to individual clients - educating clients about services - reviewing and prioritizing cases within workers caseload	- initiating case conferences - providing direct services for clients - termination when goals achieved - authorization of service provision before it can begin - following clients into nursing homes
Inter-agency or System Related Tasks		- identify and report gaps in service in the community - working supportively with service providers - community education, training and public relations - case consultation to other agencies	- authorizing service provision before it can begin - following clients into nursing homes - resource development (for groups of clients) - initiating case conferences
Knowledge and Reporting Tasks	- knowledge of community resources - knowledge of regulations and policies of service providers and funders		- reporting by unit cost

to include a breakdown of tasks into three categories: client related, inter-agency or delivery system related and knowledge or reporting related. These categories are not meant to be mutually exclusive as some tasks have consequences for both individual clients and delivery system conditions. For example, prior authorization before a service can begin affects the individual client as recipient of the service, agencies as service providers and the extent to which availability of specific services is regulated in the local delivery system. This analysis illustrates the primary involvement of reported case management tasks in the client related category, with considerably less activity in the system and inter-agency related area. Only two of the reported tasks, prior authorization of service provision before it can begin and following clients into nursing homes, involve an element of authority on the part of case managers. These two tasks were reported by less than half the symposium participants.

The focus on client level activities is also seen in a forthcoming monograph from the USC research team. Entry, assessment, case goal setting and service planning, case plan implementation and review and evaluation of client and program status are the basic categories for analysis of program functions at the client level.[15] At a higher level of generalization, the USC researchers have identified five fundemental dimensions of case coordination design: primary mission (client centered brokerage; service coordination, resource distribution and/or local system change; improvement of policy and/or practice); organizational base (free standing, special unit within an operational agency, consortium or federation); authority base (extent of control over funding to service providers); professional reference group (medical/health, mental health, social welfare, aging network, other); target population (most vulnerable, frail elderly, catchme area, those "in need," universal eligibility).[16] These design elements suggest dimensions along which future case coordination efforts can be developed. The USC project has documented recent operational experience. Project findings indicate wide variation in the practice of case management, with

primary emphasis on interactions between individual clients and their case managers.

Long Term Care Demonstrations

Findings from a recent review of nine long term care demonstrations[17] are instructive regarding the role of case management in community based long term care service delivery. The group of demonstrations examined were a mixed bag, some with rather limited goals (the National 222 projects which primarily sought to increase the availability of Day Care and Homemaker services in local delivery systems), while others operated with a very broad set of programmatic waivers (Triage), and still others included delivery system management components like preadmission screening for nursing home placements (ACCESS). What the projects did share, however, was a primary focus on a narrow, although crucial set of issues, outcomes for individual clients and the cost of services. Review of project documents and interviews with staff indicated the major focus of attention and energy went toward developing and implementing the intervention at the client level.[18] Analysis of the projects' experience suggested the utility of viewing long term care demonstrations as incorporating two levels of intervention, at the client level and at the service delivery level.

Project staff consistently pointed to what they identified as their "case management" process as the most important part of their demonstration model. Cross project comparisons soon demonstrated that the concept meant different things from one project to the next. In order to find patterns and regularities among the various notions of case management, a generic model of the client level intervention (case management) was developed. The model is composed of five discrete phases: intake and client inquiry, client assessment, eligibility determination, care planning and provision of services and follow-up.

Each project identified potentially appropriate clients through a referral and screening system. The character of the referral network and referral sources, initial referral criteria and responsibility for prescreening varied among the projects

in the intake and client inquiry phase. Comprehensive assessment procedures was the focus of the second phase. Here timing, instrumentation, organizational location, characteristics of assessor(s) and the presence of reliability checks were identified sources of inter-project variation. Two forms of eligibility were determined in phase three, program and target, as well as the application of methods for assessing risk and need. The major activity in care planning was the translation of data collected during assessment into a package of services for the client. Here projects differed in characteristics of the care planner(s), organizational location, relationship of care planning to assessment and the nature of care planning decision rules. The last phase of the generic case management model is service provision and follow-up. Projects varied regarding who had responsibility for plan implementation, the nature of the interface with assessment and care planning, services provided as opposed to purchased and responsibility for monitoring. These phases and variables are summarized in Table 2.[19]

These long term care demonstrations were also interventions in their service delivery systems. Unfortunately their experience in this area remains relatively undocumented. Some attempted to fill gaps in the existing continuum of care in the local communities where they operated (Wisconsin Community Care Organization for example), while others controlled access to high cost long term care services through pre-admission screening (ACCESS). Projects operating with waivers[20] (Wisconsin, Washington, Triage, ACCESS, Georgia, On Lok, the 222 Demonstrations) potentially had the capacity to alter the flow of funding for long term care services, and thereby change the character of local delivery systems. System level effects have not been adequately traced in past long term care demonstrations. The primary orientation toward interactions between clients and case managers has obscured important system level effects, effects which could significantly influence outcomes and costs for clients.

TABLE 2

LONG TERM CARE DEMONSTRATIONS[21]
Generic Case Management Model
Sources of Variation by Phase

I. Intake and Client Inquiry
- -- referral network
- -- referral sources
- -- initial referral criteria
- -- responsibility for pre-screening

II. Client Assessment
- -- timing
- -- instruments
- -- organizational location
- -- who performs the assessment?
  - -- individual or team?
  - -- professional training

III. Eligibility Determination
- -- program eligibility
- -- target group eligibility
- -- methods for assessing risk and need

IV. Care Planning
- -- who performs care planning?
  - -- individual or team?
  - -- professional training
- -- organizational location
- -- relationship to assessment
- -- care plan decision rules

V. Provision of Service and Follow-Up
- -- what organization implements plan?
  - -- interface with care planning
  - -- interface with assessment
- -- what services are provided?
- -- what services are purchased?
- -- responsibility for monitoring

One of the most striking observations of the projects reviewed concerned their authority, or lack of authority, in their local delivery systems. Greenberg, Austin and Doth have identified two dimensions of authority: scope and span.

Scope of authority refers to the breadth of impact the project has in its local delivery system. How much authority does it have over segments of the delivery system not directly involved in the delivery of home care services? For example, a demonstration project can be said to have broad scope of authority if it is responsible for pre-admission screening to nursing homes, if it has authority for prior authorization before services can begin to be delivered, or if there is involvement in discharging planning from acute hospitals.

Span of authority refers to the breadth of involvement a project has in the delivery of a range of services. The wider the project's span of authority, the more funding it is likely to control in its local service network. The most broadly conceived demonstrations with the widest span of authority control all the funding available to the target population from a variety of different sources. Triage exemplifies this approach.

Scope and span of authority are important dimensions to be considered in long term care service delivery. Authority alone however, will be hollow in the absence of adequate incentives and sanctions which can shape provider behavior in the long term care delivery system. Projects reviewed in this study were not adequately equipped with potent financial sanctions or incentives. In the absence of adequate authority and financial incentives and sanctions, projects mainly relied on informal influence, persuasion and voluntary cooperation from the diverse providers involved in long term care service delivery.[22]

Case Management: The Pivotal Role

The distinction made by Greenberg, Austin and Doth between interventions at the client and system levels in long term care demonstrations is somewhat artificial. Its purpose is to highlight the complexity of demonstration projects that are attempting

to accomplish change in patterns of service delivery at several levels simultaneously. Operational reality presents a set of circumstances where conditions within a specific local service delivery system have significant consequences for clients seeking service in that system. Case management models can be developed that can alter the character of that local delivery system by filling gaps in the continuum of care, by increasing the volume of scarce services or by controlling access to high cost services.

Case management has greater potential to influence the character of service delivery at the system level than has been demonstrated to date. At present, however, this potential is primarily a conceptual notion. Beatrice asserts, "The purpose of case management inherently implies provider change. Reducing the skewing toward institutional service guarantees that both the non-institutional and institutional-market segments will be affected. Case management functions as a long term care policy option only if these changes are effectuated over time. Therefore, successful case management, by definition, alters provider organization."[23]

Screening, assessment and care planning are tasks that are routinely identified as core case management activities. Effective and efficient targeting of client populations[24] is the objective in screening. Assessment is a comprehensive data collection effort, designed to identify and accurately report clients' functional capacity, social supports, living arrangements, disability level and economic dependency. Care planning is essentially a translation of assessment information into a service plan for the client. Care planning entails a set of decisions which produces a package of services. Fundamentally, care plan development is a resource allocation process, a range of decisions about how many, of what kinds of services will a client receive from which service providers?[25] A case manager, with responsibility for developing care plans involving multiple providers in a local delivery system, is operating as a resource allocator. Case management can be designed to enhance resource allocation authority. Interorganizational theory provides a useful perspective for understanding how case management can be structured to affect provider behavior through resource allocation.

Interorganizational Theory: The Resource Dependence Perspective

It has become axiomatic in interorganizational theory that organizations seek to protect and expand their autonomy and will resist efforts to increase their dependency on other organizations.[26] Efforts to increase coordination among service providing agencies produce increased interdependence among organization in a local service network. Coordination entails a cost to provider organizations. It constrains their capacity to operate independently. It requires interaction and consultation with other agencies. Coordination increases the level of uncertainty for agencies, introducing more or less uncontrollable elements into internal operations. Agencies spend considerable energy and time negotiating their dependencies in their local delivery systems, attempting to minimize potential disruptiveness introduced by environmental uncertainty. There is a price for involvement in collective activities like coordination and case management. That price is loss of some discretion and control over agency activities. It is paradoxical that if an agency wants to gain some control over the action of other organizations, it must give up some of its own autonomy.

Pfeffer and Salancik (1978) offer a perspective on relationships among organizations that focusses attention on the extent to which organizations' behavior can be externally controlled. They assert, "If behavior (of organizations) is externally controlled, then the design of the external system of constraints and controls is the place to begin to determine organizational actions and structures."[27] Any system of constraints and controls at the level of service delivery requires supportive structures at the institutional and managerial levels if it is to operate with optimal effectiveness.[28] Case managers working within the current long term care delivery system, without consistent management structures to enhance service integration will achieve limited goals. For some, however, one of the virtues of case management as a long term care policy reform option is precisely the fact that it can be placed within the ongoing delivery system and does not require basic restructuring of interorganizational relationships. Case management can modify the way provider organizations interact

by influencing their patterns of interdependence.

Pfeffer and Salancik (1978) specify three factors that are critical in determining the level of dependence of one organization on another: the extent to which specific resources are required by the focal organization for its continued operation and survival; the extent to which an external actor has descretion over allocation, use and regulatory authority concerning critical resources; and the extent to which there are few alternatives open to the focal organization for acquisition of the required resource. These factors suggest that if case management is to alter provider behavior, by increasing interdependence in the delivery system, it should be deliberately structured as a system of constraints and controls along the following lines: 1) the case manager would control a resource seen as important by service providers; 2) the case manager would have authority over resource allocation and regulate utilization of resources; 3) resource control would be concentrated in the case management function, eliminating other alternatives for service providers. These basic characteristics can be elaborated further.

Case Manager as Resource Allocator and Shaper of Provider Behavior

Two categories of variables appear to affect the ability of a case manager to shape the behavior of provider agencies: variables concerning the nature of the local delivery system and variations in the structure of case management itself. These are summarized in Table 3.

It is important to remember that case managers function within an ongoing delivery system. Characteristics of local service networks vary from one community to another. This variation must be taken into account when developing and implementing a case management mechanism. There is no single model of case management that can be placed within every delivery system. Location contingencies can be identified through comprehensive system mapping and will include an assessment of the system's completeness (how complete is the continuum of care? what gaps exist?), skew (how sharply is the system skewed toward institutionally based long term care services?), complexity

TABLE 3

VARIABLES AFFECTING CASE MANAGER
CAPACITY TO SHAPE PROVIDER BEHAVIOR

Delivery System Variables	Case Management Variables
1. System Capacity -- completeness -- skew -- complexity -- quality	1. Discretion over Allocation and Use of Critical Resources -- span of authority -- scope of authority -- financial incentives
2. Service Providers' Control Over Critical Resources -- referrals -- assessment data	2. Centralization of Resource Control -- fragmented funding -- financial reform

(how dense is the population of providers? how much duplication and overlap of service delivery exists in the system?), and quality (as assessment of quality of care and service provision). The case management model ultimately implemented in any local service network should be a product of that network's characteristics and the functions case management is intended to perform.[29]

A second significant characteristic of the delivery system is the presence of countervailing power on the part of providers to resist case management controls. At issue here is the level of dependency that exists between providers and case management regarding control of critical resources: funding, clients, and information. Case manager control over provider behavior may be limited by the extent to which case managers are dependent upon providers for appropriate referrals and assessment data. If client identification and assessment activities are decentralized to a variety of locations in the community and performed by provider agency staff,[30] case managers will have to deal with significant dependencies for clients and information. A more centralized, single point of entry, case management system is a structural option that would minimize the countervailing power of service providers to resist case management controls. Providers can be expected to attempt to protect whatever power they possess in dealing with case managers. Degree of centralization is a core case management design issue.[31]

Turning to dimensions of case management itself, discretion over the allocation and use of critical resources is key. The kind and extent of authority the case manager will have in allocating resources will fundementally affect the capacity of case managers to change provider behavior. Discretion over the allocation of resources has three elements: span of authority, scope of authority and financial incentives.[32] Span of authority refers to the width of the range of services over which the case manager has control. Wide span would include authority to allocate funds for acute care, home care and nursing home care. Case managers operating with the widest span would control allocation of all funds available to members of a

specific target population from a variety of different sources (e.g. Medicare, Medicaid, Title XX, Title 3).

Scope of authority in resource allocation concerns the breadth of impact the case manager can have in different portions of the delivery system. To what extent can the case manager control access to and use of nursing home services and acute care? Case managers operating with broad scope would be involved in hospital discharge planning, pre-admission screening, follow up after admission to nursing homes and prior authorization. These mechanisms enhance the case manager's ability to effectively and efficiently target services on identified client subpopulations by controlling utilization and access to high cost services. Case management can also be implemented with narrow scope where case managers monitor service plan development and provider contracts.

Case management can be structured to provide authority to design financial incentives and sanctions that can be utilized to produce desired provider behavior and to change market characteristics. System capacity could be enhanced through the provision of incentives to develop services missing in the local continuum of care. Target budgets can be introduced as cost control measures, including ceilings on budgets for individual clients or on budgets for specified catchment areas. Capitation of service costs is another available alternative.

The extent to which case managers have discretion over the allocation of resources is closely related to the degree to which resource control is centralized. In the current system of fragmented funding, case managers are likely to control only a portion of the resources for any given client. Programmatic waivers, like those operating in some of the long term care demonstrations discussed above, were necessary in order to create a pool of funds that case managers could control. Fragmented funding allow providers to charge the costs of services received by eligible clients directly to those programs for which the client is eligible. Prior authorization and pre-admission screening mechanisms are appropriate methods for control of utilization and access to services.

A variety of options concerning possible financial reforms in financing long term care are being offered.[33] These range from cash and benefit approaches to long term care bloc grants and the creation of Social/Health Maintenance Organizations (S/HMO). The options vary with respect to their economic and political feasibility, the breadth of services covered, accessibility to clients, impact on providers, cost and management issues. The character of care level coordination within each of these approaches remains to be seen. Financial reform options differ regarding the extent to which they would integrate funding for long term care and the relationship of the flow of funding to the structure of the delivery system. For example, the S/HMO model involves greater centralization of service delivery than social insurance approaches. In contrast, the Long Term Care Block Grant approach integrates funding streams, but does not in itself suggest restructuring of organizational relationships in the delivery system.

Experimentation with alternative financial reforms in long term care is an important agenda item for the 1980's. S/HMO projects are being planned and the first group of Channeling demonstrations will begin service delivery shortly. The National Long Term Care Channeling Demonstration Projects fall into two groups, basic and complex. Basic channeling models involve an approach to case management that emphasizes client level activities (outreach, screening, assessment, care planning, arranging for services, follow-up, monitoring and reassessment).[34,35] Complex channeling models[36] are currently being developed and may provide an opportunity to experiment with a broader notion of case management. The extent to which the case manager has authority over resource allocation in the complex channeling demonstrations will be an indication of just how incrementally it is necessary to approach the testing of a case management model that has some leverage with service providers.

Conclusion

It has been argued that case management as implemented in programs for the elderly, particularly in long term care demonstration projects, has focused on the interactions between the client and the case manager around assessment, care planning, service plan implementation and follow-up. Variation in these case management tasks, suggests that no single model can be implemented in all local delivery systems. Case management is of necessity location contingent, since it is a coordinative mechanism that is placed within an on-going delivery system.

The emphasis on client/case manager interaction has obscured the fact that care planning, a core case management task, is a crucial resource allocation activity and has important consequences for the distribution of resources within a local delivery system. A resource dependence view of interorganizational relationships was offered as a useful perspective for analyzing the capacity of case managers to change market conditions by altering service providers' behavior. The extent of discretion over resource allocation and centralization of resource control were identified as key case management design issues.

Case management has been described as a middle ground long term care policy reform option. Its implementation does not require fundemental changes in funding patterns or interorganizational relationships. Perhaps this is why it is so widely accepted, particularly when its major emphasis has been on case level coordination. The middle ground in which case management can be developed as a reform option is wider than present operational experience suggests. Models that expand case management to include authority for resource allocation and implementation of financial incentives to influence market conditions deserve greater attention.

FOOTNOTES

[1]For a comprehensive discussion and analysis of the Service Integration experience see the entire issue of Evaluation, Vol. 3, Nos. 1-2, 1976; Caragonne, Penelope, "Bibliography on Service Integration Literature," Center for Social Work Research, School of Social Work, University of Texas at Austin, December 1977, unpublished report; Evaluation of Services Integration Demonstration Projects, Human Services Bibliography Series, #1, June 1976, Project Share, Rockville, MD.

[2]Mittenthall, Stephen D. "A System Approach to Human Services Integration," Evaluation, Vol. 3, Nos. 1-2, 1976, pp. 142-148.

[3]The Hartford SITO project pooled funds from the State Department of Welfare, State Division of Aging, City of Hartford, United Way and private foundations. A new organization, the Community Life Association, was created.

[4]Complete Case Coordination Bibliography, Andrus Gerontology Center, University of Southern California, 1978.

[5]1979-80 National Directory of Case Coordination Programs for the Elderly, Andrus Gerontology Center, University of Southern California, 1980.

[6]Handbook of Guidelines and Models for Development, Implementation and Evaluation Of Case Coordination Programs for the Elderly, Andrus Gerontology Center, University of Southern California, in press 1981.

[7]Steinberg, Raymond (ed.). Case Coordination and Service Integration Projects: Client Impact, Program Survival and Research Priorities, Three papers delivered at the National Conference on Social Welfare, Los Angeles, May 1978; Carter, Genevieve, "Service Coordination: A Recycling of Tested Concepts;" Steinberg, Raymond, "Case Coordination: Lessons from the Past for Future Program Models;" Evans, Eunice, "An Integrated Social Service Delivery System."

[8]Case Coordination with the Elderly: The Experiences of Front Line Practitioners, Proceedings and Summary of Findings from the Symposium held January 20-22, 1979, Andrus Gerontology Center, University of Southern California, February 1979.

[9]Downing, Rachel. Three Working Papers: An Exploration of Case Manager Roles: Coordinator, Advocate and Counselor; Issues of Client Assessment in Coordination Programs; Client Pathway, Andrus Gerontology Center, University of Southern California, March 1979.

[10]Ibid.

[11]Steinberg, Raymond M. "Case Service Coordination: Senior Center Issues," presented at Annual Conference of the National Council on Aging, 1978.

[12]Steinberg, Raymond M. Area Agencies on Aging: Case Study of a Controversial Purchase of Service Contract, Andrus Gerontology Center, University of Southern California, 1979.

[13]Participating agencies were: Multi Service Center, Wheeling, WV; Project Independence for the Elderly, Paducah, KY; Metropolitan Family Service Inc., Portland, OR; Monroe County Long Term Care Program-ACCESS, Rochester, NY; Senior Information and Outreach Service, Houston, TX; Triage, Inc., Plainville, CT; Jewish Family and Children's Services, Miami, FL; Cambridge Somerville Home Care Corporation, Somerville, MA; Visiting Nurse Association of Milwaukee, Milwaukee, WI; Family Counseling Agency, Tuscson, AZ; Department of the Visually Handicapped, Richmond, VA; Jamaica Service Program for Older Adults, Inc., Jamaica, NY.

[14]adapted from: Case Coordination with the Eldery: The Experiences of Front Line Practitioners, Proceedings and Summary of Findings from the Symposium held January 20-22, 1979, Andruse Gerontology Center, University of Southern California, February 1979, pp. 76-77.

[15]Steinberg, Raymond M. & Genevieve W. Carter, excerpts from Handbook for Development, Implementation and Evaluation of Case Coordination Programs for the Elderly, forthcoming, Andrus Gerontology Center, 1981.

[16]Ibid.

[17]Greenberg, Jay, Carol Austin and David Doth, A Comparative Study of Long Term Care Demonstrations: Lessons for Future Inquiry, in press, Project Share. The projects reviewed included: Alternative Health Services, Atlanta, GA; Alternatives to Institutionalization, Worcester, MA; Community Based Care Systems, State of Washington; Community Care Organization, Madison, WI; Effects and Costs of Day Care and Homemaker Services (six projects located in: Los Angeles; San Francisco; Lexington, KY; White Plains, NY; Syracuse, NY; Providence, RI); Highland Heights, Fall River, MA; Monroe County Long Term Care Program-ACCESS, Rochester, NY; On Lok Health Center, San Francisco, CA; Triage, Inc., Plainville, CT.

[18]For a more thorough discussion of this distinction, see Greenberg, Austin & Doth, op.cit.

[19]For an indepth discussion of the ways in which the reviewed projects varied on these dimensions of the generic case management model, see Greenberg, Austin & Doth, op.cit.

[20]The demonstrations reviewed included projects operating with 1115 waivers of the Medical Assistance Program and/or 222 waivers in the Medicare Program.

[21]Adapted from Greenberg, Austin & Doth, op.cit.

[22]For a description of the variety of approaches that can be taken to design long term care demonstrations with increased authority and financial incentives, see Greenberg, Austin & Doth, op.cit.

[23]Beatrice, Dennis F., "Case Management: A Policy for Long Term Care," in Reforming the Long Term Care System, Callahan & Wallack (eds.), Lexington Books, D.C. Health & Co., Lexington, MA, 1981, p. 156.

[24]For a discussion of the distinction between effective and efficient targeting, see Frederick W. Seidl, Kevin Mahoney & Carol D. Austin, "Providing and Evaluating Home Care: Issues of Targeting." Paper presented at the Thirty first Annual Scientific Meeting of the Gerontological Society, Dallas, TX, November 1978.

[25]For a discussion of the service allocation process within the organizational context of provider agencies, see Austin, Carol, "Client Assessment in Context," Social Work Research & Abstracts, Vol. 17, No. 1, Spring 1981, pp. 4-12.

[26]See for example, James D. Thompson, Organizations in Action (New York: McGraw Hill Book Co., 1967); Ephraim Yuchtman and Stanley Seashore, "A System Resource Approach to Organizational Effectiveness," American Sociological Review, 32 (December 1967), pp. 891-903; Sol Levine & Paul E. White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," Administrative Science Quarterly, 5 (March 1961), pp. 583-601.

[27]Pfeffer, Jeffrey & Gerald R. Salancik, The External Control of Organizations: A Resource Dependence Perspective, Harper & Row, New York, 1978, p. 281.

[28]See Aiken, et.al., Coordinating Human Services, Jossey Bass, San Francisco, CA, 1975 and Callahan, James J., "Single Agency Options for Long Term Care," in Callahan, James J. & Stanley S. Wallack (eds.), Reforming the Long Term Care System, D.C. Heath & Co., Lexington, MA, 1981.

[29]For a thorough discussion of location contingencies see Beatrice, op.cit.

[30]Greenberg, Austin & Doth (op.cit.) discuss variations in organizational location of screening, assessment, care planning, service provision and monitoring.

[31]For an examination of a long term care service delivery option that maximizes centralization, the single agency approach, see Callahan, op.cit.

[32]see Greenberg, Austin & Doth, op.cit.

[33]For a thorough examination of various reform approaches see Callahan, James Jr. & Stanley S. Wallack, Reforming the Long Term Care System, D.C. Heath, Lexington, MA, 1981.

[34]see Gottesman, Leonard D., "Client-Level Functions of the Long Term Care Demonstration: The Basic Intervention," Temple University Institute on Aging, Philadelphia, PA, unpublished paper, April 1981.

[35]Basic Channeling projects provide case level coordination (case management), will have some control over social services funding (Title XX Bloc Grant funds and Title 3 Older Americans Act funds), can engage in minimal service expansion, but will receive no additional funding. Five projects will be implemented in Middlesex County, New Jersey; eight rural counties in Eastern Kentucky; Baltimore, Maryland; Houston, Texas; and Maine (an urban/rural site).

[36]Complex Channeling will be implemented in Miami, Florida; Philadelphia, PA; Greater Lynn, MA; Renseallear County, NY and Cayahoga County, Ohio (Cleveland). Current plans call for the complex channeling projects to include a Medicare Waiver (222), a means test, cost sharing with participants and case management.